Adult Screening and Immunization Documentation Form
2009 H1N1 Influenza Monovalent Vaccination Program

Circle answers to questions 1-13:			
1	Are you 49 years of age or younger?	No	Yes
2	Have you received the 2009-2010 Seasonal Influenza vaccine?	No	Yes
3	Do you currently feel sick or have a fever?	No	Yes
4	Are you taking any prescription medicines to prevent or treat influenza? Have you taken any antivirals in the last 48 hours?	No	Yes
5	Are you pregnant or planning to become pregnant in the next month?	No	Yes
6	Have you ever had a serious reaction to a flu vaccine?	No	Yes
7	Do you have an allergy to any of the following: eggs, chicken or egg protein, gentamicin, gelatin, arginine, neomycin, polymyxin B, thimerosal, formaldehyde, or other vaccine components?	No	Yes
8	Do you have a chronic health problem such as: heart disease, lung disease, asthma, kidney disease, metabolic disease (e.g., diabetes), anemia, or other blood disorder?	No	Yes
9	Do you have an active neurological disease?	No	Yes
10	Do you have a history of Guillain-Barre Syndrome (GBS)?	No	Yes
11	Has your doctor ever told you that you have an immune system disorder? Are you taking long-term steroid treatment or immunosuppressants?	No	Yes
12	Do you have HIV, AIDS, cancer, or have you received an organ transplant?	No	Yes
13	Do you live with or have close contact with severely immunocompromised individuals or someone who must be in a protective environment (such as transplant recipients?)	No	Yes
14	Have you received any vaccines within the last 30 days or do you plan to receive any vaccines in the next four weeks?	No	Yes
15	<u>If you are 49 years of age or younger</u> please list below all of the medications you are currently taking (*for medication reconciliation*):		

"I have read or have had explained to me the information in the 2009 H1N1 Influenza Monovalent Vaccine Information Statement (VIS). I have also had a chance to ask questions and they were answered to my satisfaction. I understand the benefits and risks of the influenza vaccine."

Signature: _____ Date: _____

Below to be completed by healthcare provider

☐ **Give injectable H1N1 flu vaccine today** ☐ **Give intranasal H1N1 flu vaccine today** ☐ **Do not administer H1N1 flu vaccine today**	**Vaccine Information Statement provided (check box)** ☐ Inactivated, H1N1 Influenza Monovalent Vaccine ☐ Live, H1N1 Influenza Monovalent Vaccine
	Interviewer's Signature / **Date**

Vaccine Administered

☐ **Live Intranasal H1N1 Influenza** (MedImmune) **Lot #** _____ **Dose: 0.2 ml Route: Intranasal**	☐ **Inactivated H1N1 Influenza** (Sanofi-Pasteur) **Lot #** _____ **Dose: 0.5 ml Route: IM Left/Right Deltoid**
☐ **Inactivated H1N1 Influenza** (CSL) **Lot #** _____ **Dose: 0.5 ml Route: IM Left/Right Deltoid**	☐ **Inactivated H1N1 Influenza** (Novartis) **Lot #** _____ **Dose: 0.5 ml Route: IM Left/Right Deltoid**
Name: **DOB:** **Sponsor SSN:**	**Administered by:** / **Date**